Kentucky Reentry Courts: Evaluation of the Pilot Programs

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This document was developed under grant number SJI-01-007 from the State Justice Institute. The points of view expressed are those of the authors and do not necessarily represent the official position or policies of the State Justice Institute.

Executive Summary

As record numbers of offenders return from prison to the community each year, many policy makers and stakeholders are beginning to realize that "they all come back." Not only do they come back, but many of them also return to the community having had little or no help for their drug and psychological problems while they were behind bars, and they are unlikely to get treatment services after they return to the community. Without treatment many of these individuals likely will return to prison.

Reentry Courts represents an important step toward developing innovative programming for drug-involved offenders. In Kentucky, the Reentry Court model program that was developed combined 6-months of in-prison treatment with at least 1 year of treatment in an established Drug Court upon return to the community. A growing body of literature strongly suggests that these programs are effective independently, and that combining them might increase the effectiveness of each.

Initial findings concerning the during-program performance of 6 clients admitted to the Kentucky Reentry Court pilot program were encouraging. As of November 21, 2001, 5 of the 6 clients were still active in treatment (1 had absconded). These individuals showed high levels of behavioral compliance with treatment expectations. Several were promoted to either phase 2 or phase 3 of the Drug Court, none had tested positive for and illicit drug on urine tests, none had received a new criminal charge, and most were employed; whereas, the majority were unemployed prior to entering Drug Court. Nevertheless, the Kentucky Reentry Court program was discontinued due to funding concerns, namely federal funding was not readily available to continue these efforts. For program like this to impact a large number of lives, federal funds need to be

made available to expand the capacity of both corrections-based programming and Drug Courts. By doing so, it might be possible to begin to slow the revolving door that many drug-involved offenders to repeatedly recycle through the courts and corrections.

In addition, to examining the preliminary outcomes of those who were admitted to the Kentucky Reentry Court program model, a substudy also was conducted for developing a Treatment Screening Questionnaire. This questionnaire was designed to facilitate criminal justice decision making regarding referrals to programs like Reentry Courts. The screener emphasized a number of offender attributes (like drug use severity, mental health history, motivation for treatment, criminal history, and treatment history), highlighted by Peters and Peyton (1998) as important characteristics for Drug Courts to consider when making decisions for placing individuals in rehabilitative programming. A standardized set of instruments were included in the Treatment Screening Questionnaire, including the Simple Screening Instrument, Texas Christian University Drug Screen II, Salient Factor Score, and the Desire for Help Scale from the Texas Christian University Treatment Motivation Assessment. Initial finding from pilot data collected from 39 residents of a corrections-based therapeutic community (a program that was used by some of the Reentry Court clients in this evaluation) were encouraging. Overall, residents were willing to provide detailed information on their drug use and drug use problems, mental health problems, criminal history, and treatment motivation. Their responses on the questionnaire were internally consistent, indicating high levels of reliability. Self-reported information also demonstrated a high level of agreement with information abstracted from official records, suggesting good validity. Therefore, it appears that the Treatment Screening Questionnaire may be a useful tool for helping

correctional and Drug Court managers to determine who might warrant further assessment and entry into a treatment program.

In conclusion, the Kentucky Reentry Court Pilot program was grounded in the literature that shows residential treatment and Drug Courts are effective for reducing recidivism and relapse among drug-involved offenders. Initial findings from analysis of during-program performance indicators showed that most of the clients admitted to the Reentry Court program were doing well in it. Therefore, additional federal monies should be made available to more thoroughly test innovative programs for helping offenders reenter and reintegrate into the community, like the one described in the current report.

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BACKGROUND AND OVERVIEW

Need for Reentry Programming

"But they all come back" is a fact that is being increasingly recognized both by federal and state policy makers as well as the public and news media as increasingly larger numbers of offenders return to the community after serving prison and jail sentences (Travis, 2000). Correctional populations expanded at unprecedented levels during the 1990s, with nearly 6 million held in some form of custody at the end of 1998 (Bureau of Justice Statistics, 1999a). At yearend 1999, over 2 million offenders were held in prisons and jails, yielding an incarceration rate of about 1 in every 137 Americans (Bureau of Justice Statistics, 2000). Besides having extensive and serious criminal histories, many of these prisoners exhibit numerous social and psychological problems, including substance use and abuse (Bureau of Justice Statistics, 1999d; Leukefeld & Tims, 1993, National Center on Addiction and Substance Abuse, 1998; Peters, Greenbaum, Edens, Carter, & Ortiz, 1998), mental illness (Bureau of Justice Statistics, 1999b; Teplin, 1990, 1994), co-occurring substance abuse and mental health problems (Abram & Teplin, 1991; Kayo, Hiller, Narevic, & Leukefeld, 2000; Peters & Hill, 1993), and histories of physical, sexual, and emotional trauma (Bureau of Justice Statistics, 1999c; Hiller, Knight, Rao, & Simpson, in press).

Larger state and federal prison populations, in turn, means that increasingly larger numbers of offenders are released each year to some form of community supervision, like probation or parole. Recent estimates suggest that over 500,000 offenders were released to the community in 1999 (Department of Justice, 1999), and nearly 600,000 were

released in 2000. Reflecting the prison and jail populations they have just left, offenders on supervised release have serious psychological and social problems, like substance abuse (Bureau of Justice Statistics, 1998), mental illness (Bureau of Justice Statistics, 1999b), and concurrent substance abuse and mental health problems (Hiller, Knight, Broome, & Simpson, 1996). This rising influx of probationers and parolees threatens to swamp already overburdened community corrections agencies. Indeed, while expenditures for prisons and jails have grown steadily over the last decade, probation and parole departments have seen no such increase. Therefore, probation and parole agencies are being asked to do more, without additional resources, during a time in which the profiles of their clientele have become more serious, rivaled only by those in prison (Petersilia, 1995; 1997).

Office of Justice Programs Reentry Courts Initiative

Innovative programs were developed in several sites across the nation to transition offenders from the institution to the community. Building on the successful and cost-effective Drug Court model where judicial authority is used to apply graduated sanctions and rewards while case managers help broker treatment resources (see Belenko 1998; 1999; Peters & Murrin, 2000), these "Reentry Courts" represent a timely and important adaptation of this effective approach to help meet the programming needs evident in parole and probation populations. This is particularly noteworthy because, although residential programs like halfway houses (Latessa & Allen, 1982; Latessa & Travis, 1991; Turner and Petersilia, 1996) and transitional therapeutic communities (Inciardi, Martin, Butzin, Hooper, & Harrison, 1997; Martin, Butzin, Saum, & Inciardi, 1999; Hiller, Knight, & Simpson, 1999) have been shown to be effective for helping

offenders to reintegrate into the community, these approaches tend to be somewhat expensive and their use is limited. Reentry Courts, however, represent a potentially cost-effective means for providing treatment to probationers and parolees.

Historically, Jeremy Travis introduced the concept of the Reentry Court in 1998 at the National Corrections Conference (National Drug Court Institute, 1999). In February 2000, the Office of Justice Programs began the Reentry Courts Initiative (OJP-RCI), designed to provide technical assistance to jurisdictions interested in developing Reentry Courts (National Institute of Justice, 2000). Nine pilot sites were selected, including teams from California, Colorado, Delaware, Florida, Iowa, Kentucky, New York, Ohio, and West Virginia. The first cluster meeting for the RCI workgroups was held in February 2000 (Office of Justice Programs, 2000), the second was held in September 2000, and the third was held in April 2001. It was hoped that Reentry Court models could be developed to address many special needs among offenders returning to the community. Many of the pilot Reentry Court Programs were designed to provide or broker services for drug-involved parolees (including the Kentucky Reentry Court Program), other pilot programs focused on those offenders who were returning to the community after serving time for domestic violence charges, and others were planned to focus on transitioning mentally ill offenders and offenders with concurrent diagnoses of serious mental illness and substance abuse dependence. One pilot Reentry Court targeted only Juvenile offenders returning to the community after long-term detention.

Goals of the Current Evaluation Report

The State Justice Institute (SJI) funded the Kentucky Administrative Office of the Courts (AOC) to examine the Reentry Court Pilot program developed under its auspices

(Award# SJI 01-007). AOC then funded a Memorandum of Agreement with the University of Kentucky Center on Drug and Alcohol Abuse to evaluate the Kentucky Reentry Court Pilot Program. The purpose of the current report is to summarize evaluation finding and review the process of the development of the Kentucky Pilot Reentry Courts, and the ultimate discontinuation of the use of this approach in Kentucky Courts. This report will meet 3 specific goals.

1. **Provide a review of selected literature for the components of the Kentucky Reentry Court Pilot Program,**
2. **Describe demographic and outcome data for the individuals who participated in the Kentucky Reentry Court Pilot Program.**
3. **Examine the development of a treatment screening questionnaire for use with the criminal justice based treatment programming.**

KENTUCKY REENTRY COURTS PILOT PROGRAM MODEL AND LITERATURE REVIEW

The Kentucky Reentry Court Pilot Program Model

Concept paper. The original concept paper for establishing Reentry Courts in Kentucky submitted to the Office of Justice Programs Reentry Court Initiative (OJP-RCI) called for Kentucky Reentry Courts Pilot Program to focus on and expand the capacity of Drug Courts in two communities - Louisville/Jefferson County and Lexington/Fayette County - which represent the state's longest-running and largest Drug Courts and those that are located in the most populated areas of the state. The offender population targeted under the original concept paper submitted to OJP-RCI was felony offenders, especially those with alcohol or other drug abuse problems.

These individuals were intended to receive treatment services under the proposed model through the Reentry Drug Court which would use a "split sentencing" scheme -- to have offenders to serve a portion of their time in correctional institutions, after which the judge would require the reentry client to complete the remaining part of their sentence under strict supervision in the Reentry Court. Three Reentry Court phases were proposed, through which offenders in reentry Drug Court would pass. Each would include intensive contact with the Drug Court judge, alcohol and/or drug treatment, and frequent drug testing. As participants completed these phases, they would move toward less intensive supervision providing that they maintained sobriety, obtained and maintained employment, attended required meetings, and complied with all other elements of the program. The judge, correctional staff, and reentry Drug Court staff were to maintain communication with the offender throughout the program to ensure participant accountability and public safety.

The original Kentucky reentry concept paper also indicated that these pilot programs would be supported by teams of representatives from the Kentucky Administrative Office of the Courts, the Department of Corrections, and community service providers in the two pilot communities. The Center on Drug and Alcohol Research at the University of Kentucky was proposed as the agency responsible for evaluating the pilot program and for providing and providing feedback on program success and areas for improvement.

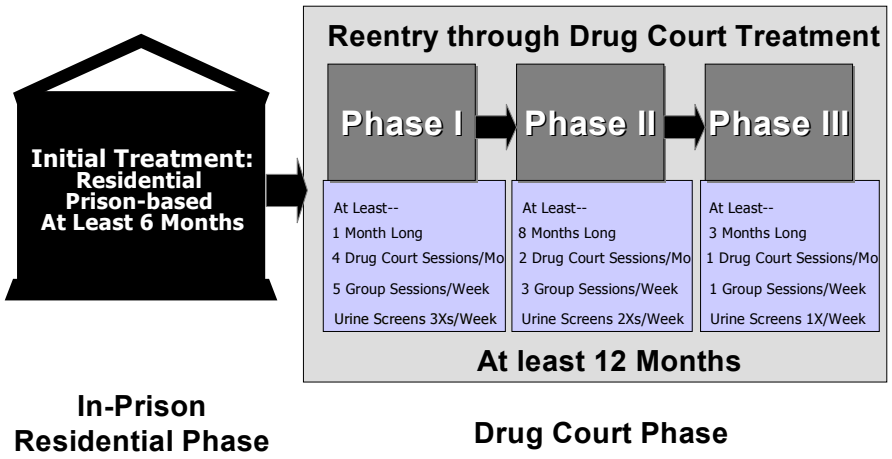
Final model. The initially proposed Kentucky Reentry Court Program model was refined from the one presented in the initial concept paper through team meetings, the OJP-RCI cluster meetings held in April and September 2000, and a review of the criminal justice treatment literature (elements of which are summarized in the next section of this report). Essentially the final Kentucky Reentry Court Pilot Program model (shown in Figure 1) built on the evaluation literature that shows that corrections-based residential treatment and court-based Drug Court models are each effective for reducing recidivism and drug use following release. The final Kentucky Reentry Court Program model, therefore, included two major phases of treatment mirroring the correctional status of the offender (i.e., in-prison phase and Drug Court phase). The in-prison treatment phase occurred in a correctional institution (usually an in-prison therapeutic community), and the Drug Court phase of treatment occurred at reentry to the community through an established Drug Court program. It was believed that by combining two treatment approaches shown to be effective independent of each other, that an even greater additive impact would be realized through a "one-two punch" of residential and outpatient treatment.

Although Reentry Courts were originally planned for Jefferson and Fayette County Kentucky, programs were considered finally for Campbell County, Fayette County, and Warren County. Operational Reentry Court pilot programs were established only in Campbell and Fayette counties. Judges for these two pilot programs assigned a total of 7 clients to the Reentry Court (description of these clients and outcomes are described later in this report). These clients were placed in 6 months of residential prison-based substance abuse treatment (either a therapeutic community or a psychoeducational substance abuse treatment program), and then "shock probated" by the Judge after successful completion of the prison-based residential treatment and placed under the active supervision of established Drug Courts in these two counties upon community reentry -- intended to last a minimum of 12 months. Comprehensive process evaluations are available on these two Drug Courts (see Logan, Leukefeld, & Williams, 1999; Logan, Williams, Leukefeld, & Lewis, 1999, Logan, Williams, Leukefeld, & Minton, 2000).

As shown in Figure 1, these two Drug Courts followed the 3-phase Kentucky Administrative Office of the Courts Drug Court model, with the most intensive supervision and intensive treatment emphasized in the first phase of Drug Court treatment. Reentry Court clients were expected to remain in Drug Court Phase 1 for at least 1 month, during which they would attend a minimum of 4 Drug Court sessions and 5 treatment sessions per week, and they were expected to submit at least 3 urine screens for drug testing each week. Once phase I requirements were satisfied, reentry clients could then be promoted to the second phase of Drug Court, which was expected to last at least 8 months. During phase II, they were expected to attend at least 2 Drug Court

session per month, attend at least 3 treatment sessions per week, and submit urine two times a week for drug screening. The final phase of the Drug Court (sometimes referred to as the aftercare phase and usually lasting at least 3 months), focused on transitioning the client to independent drug-free, crime-free living. Supervision was accomplished through attendance at 1 Drug Court session per month, and through 1 urine drug screen per week. Clients in Drug Court Phase III were expected to attend at least 1 treatment session per week.

Figure 1. Model for the Kentucky Reentry Courts Pilot Programs



Discontinuation of the model. Ultimately it was decided by the Reentry Court team to discontinue admitting new clients into the Reentry Court Pilots Program, but to allow all who already had been identified as needing Reentry Court to finish the pilot program. The reason for discontinuing the Reentry Court model focused primarily on lack of resources. No federal grant money was available for continuation of the model in its current format, or for innovative reentry programming.

Literature Review for Reentry Court Pilot Program Elements

A growing body of literature shows that the model described in Figure 1 represents a combination of two criminal justice-based approaches that "work" for reducing recidivism and relapse among drug-involved offenders and for improving the supervision of drug-involved offenders when they are in the community. This is important, because rehabilitation-oriented programming has been increasing over approximately the last decade after an era in which it was commonly believed that "nothing works" for rehabilitating the criminal offender. A number of different criminal justice-based treatment models have been developed both in corrections and in courts, and in-prison residential treatment (e.g., therapeutic community) and treatment Drug Courts are among the most researched and effective models currently used for rehabilitating and reintegrating drug-involved offenders into the community. The following is a selected review of the literature summarizing the effectiveness of specific models programs for prison-based and Drug Court-based treatment of drug-involved offenders.

Prison-based treatment studies. Research has shown that focused rehabilitation-oriented programming can reduce criminality and drug use following incarceration (Andrews et al., 1990; Gendreau, 1996). Particularly within prisons, long-term residential treatment programs (such as therapeutic communities, TC), have been found to reduce post-incarceration drug use and criminal activity (Lipton, 1995). These findings are highlighted in a congressionally-mandated review completed by the University of Maryland, Preventing Crime: What Works, What Doesn't, What's Promising (MacKenzie, 1997), and the NIDA-funded Correctional Drug Abuse

Treatment Effectiveness (CDATE, Lipton, Pearson, Cleland, & Yee, 1998; Pearson & Lipton, 1999) meta-analysis.

Several major large-scale evaluations of in-prison therapeutic communities (ITC) have been completed, including earlier studies conducted at the Cornerstone and Stay'n Out programs. These initial evaluations found treatment was associated with reduced rearrest and reconviction rates and with better parole outcomes (Field, 1985, 1989, 1992; Wexler & Williams, 1986; Wexler, Falkin, & Lipton, 1990; Wexler, Falkin, Lipton, & Rosenblum 1992). These finding encouraged the development of more in-prison therapeutic community programs, eventually leading to the Federal Residential Substance Abuse Treatment (RSAT) initiative that provided grant dollars for establishing more prison-based TCs.

More recent research evaluations of prison-based TC drug treatment have shown findings similar to those reported for the Stay'n Out and Cornerstone programs. These newer evaluations include the examination of model in-prison TC programs, including Delaware's KEY-CREST (Martin, Butzin, & Inciardi, 1995), California's Amity (Wexler & Graham, 1994; Lowe, Wexler, & Peters, 1998), and Texas' Kyle New Vision (Knight, Simpson, Chatham, & Camacho, 1997) programs. University-based research teams have evaluated all of these programs, and at least 3 years of posttreatment outcomes are available for individuals treated in these programs as well as matched comparison groups. It is worth noting, however, that although each TC program represents the intensive "treat-the-whole-person" approach characteristic of therapeutic community treatment, not all programs were followed with well-organized transitional care when treatment graduates returned to the community--thus reducing positive outcomes.

The KEY-CREST programs, evaluated by the Center for Drug and Alcohol Studies at the University of Delaware through an award from the National Institute on Drug Abuse, represent a continuum of care that mirrors the offenders' custody status (Inciardi, Martin, Butzin, Hooper, & Harrison, 1997). Prisoners with a history of drug-related problems are identified and referred to the KEY Therapeutic Community (TC) program, and following prison release, these individuals go to the CREST program, a TC-based work-release program for transitional care (Nielsen, Scarpitti, & Inciardi, 1996; Lockwood, Inciardi, & Surratt, 1997). Finally, after release from the transitional residential care, the clients enter receive a phase of supervised outpatient-based aftercare. Six-month, 18-month, and 3-year outcome data have been published on this continuum of care. Six-month post-release relapse and recidivism for graduates of both KEY and CREST were significantly lower than for program dropouts and a non-treatment comparison group (Martin et al., 1995; Nielsen et al., 1996). Eighteen-month findings also showed 54% of those who completed both the prison-based and residential work-release aftercare components of treatment had used an illicit drug during the follow-up, and 27% had been rearrested (Inciardi et al., 1997). In contrast, 76% of those who only completed the prison-based TC treatment program had used drugs in the 18-month period, and 55% had been rearrested. An untreated comparison group had the poorest outcomes; 85% had relapsed to drug use and 56% had been rearrested for a new offense. Outcomes were still good even after 3 years had elapsed between prison-based treatment and release to the community. Significantly more of the clients who completed the in-prison program and the transitional aftercare program remained arrest-free during the follow-up (55%) than an untreated comparison group (29%, Martin, Butzin, Saum, &

Inciardi, 1999). Those who also had received outpatient aftercare following the transitional residential treatment had the best outcomes (69% were arrest free even after 3 years). Results for relapse to drug use were similar, with 17% of those who completed only the in-prison therapeutic community, 27% who had the in-prison treatment and the transitional residential treatment, and 35% who also had outpatient aftercare remaining drug-free during the follow-up interval (compared to only 5% of the comparison group, Martin, Butzin, Saum, & Inciardi, 1999).

Following their evaluation of the Stay'n Out TC in New York, researchers at the Center for Therapeutic Community Research began a study of California's Amity program (Wexler, De Leon, Kressel, & Peters, 1999). Located in the Donovan Prison in San Diego, this 1-year residential modified TC includes treatment slots for 200 substance abusers near the end of their sentence term. Upon prison release, parolees may be admitted to a 40-bed community-based TC for transitional aftercare (Wexler & Graham, 1994), so not all of those who received in-prison treatment also receive transitional care upon return to the community. One-year outcomes showed that only 25% of those who participated in both the prison and the community-based residential aftercare programs were reincarcerated. This was significantly lower than the reincarceration rates for a group of individuals who did not complete the prison-based program (64%), for those that completed the prison-based TC but did not participate in the aftercare program (66%), and for untreated comparisons (67%). Likewise, those who completed both the prison-based TC and aftercare programs had the lowest drug use relapse rate, with only 25% reporting any illicit drug use, compared to 64% of the prison-based TC dropouts, 66% of the TC completers, and 67% of the comparison group. Three-year post-parole

outcome data showed that only 27% of those who received both in-prison and transitional treatment were reincarcerated during the follow-up interval, compared to 75% reincarceration rate for those in the comparison group, 79% who completed on the in-prison treatment, and 82% for those who were in-prison treatment dropouts (Wexler, Melnick, Lowe, & Peters, 1999).

The Kyle New Vision program was the first in-prison therapeutic community (ITC) developed under 1991 state legislation that outlined plans for several corrections-based substance abuse treatment facilities in Texas (Eisenberg & Fabelo, 1996). It is a 500-bed facility that provides treatment to inmates during the final 9 months of their prison term. After release, parolees are mandated to attend 3 months of residential aftercare in a transitional therapeutic community (TTC), followed by up to another year of supervised outpatient aftercare. An evaluation conducted by Texas Christian University (TCU) revealed that 3% of those who completed both ITC and TTC programs were rearrested within 6 months of their release from prison, compared to 15% of those who only completed the ITC (but failed to finish the TTC), and to 16% of an untreated comparison group (Knight, Simpson, Chatham, & Camacho, 1997). Furthermore, results from hair specimens collected during a 6-month follow-up indicated 35% of those who completed both the ITC and TTC tested positive for cocaine (the primary drug of choice for those in the sample), compared to 47% for the group that completed only the ITC, and 54% for the comparison group (Knight, Hiller, Simpson, & Broome, 1998). TTC completion following the ITC was the strongest predictor of remaining arrest-free for 2 years following release from prison, and aftercare completion was strongly associated with parolee satisfaction with these programs (Hiller, Knight, & Simpson, 1999).

Analysis of 3-year outcome data showed that in-prison treatment followed by aftercare was most effective and cost-effective for high-risk, high-needs offenders (as measured by the Salient Factor Score, Knight, Hiller, & Simpson, 1999; Griffith, Hiller, Knight, & Simpson, 1999).

Collectively, the evaluations summarized above underscore the importance of providing transitional services to offenders following prison-based treatment. Finding from the Key-Crest, Amity, and Kyle NewVision programs clearly and consistently showed that the best outcomes, in terms of reduced recidivism and drug use, were realized only among those who received transitional care services as they returned to the community. Drug Courts obviously represent an important means for transitioning offenders to the community, especially because they have also been shown to be effective for reducing recidivism and relapse among drug-involved offenders.

Drug Court treatment studies. Only a brief review of the Drug Court treatment effectiveness literature is presented here because extensive reviews are readily available on this subject (see Belenko, 1998, 1999, 2001; Peyton, & Gossweiler, 2001). Nevertheless, it is important to cover some of this literature to help emphasize that joining residential prison-based treatment with Drug Court represents an important combination of independently effective "best practices" approaches. The most recent data indicate that there are 483 adult, 158 juvenile, 38 family, and 9 combined Drug Courts nationwide, for a total for 688 Drug Courts. It is estimated that 220,000 adults and 9,000 juveniles have received treatment services in Drug Courts (American University, 2001).

Belenko (2001) presents a review of 37 Drug Court evaluations, including 6 studies that reported outcome data. He notes that 4 of the 6 evaluations found that Drug Courts reduce recidivism to the criminal justice system, and the most scientifically rigorous studies (i.e., random assignment to a control condition) all found reductions in recidivism rates. In terms of costs, most studies that calculated these measures found that Drug Courts helped "save" money, primarily through the reduction of recidivism. The last part of this literature review focuses on three specific rigorous evaluations of the effectiveness of Drug Courts, including evaluations of the D.C. Superior Drug Court program, of Drug Courts in Florida, and Drug Courts in Kentucky.

The evaluation of the D.C. Superior Drug Court program was conducted by researchers at Urban Institute (Harrell, Cavanagh, & Roman, 2000), who tested the effects of two experimental enhancements to Drug Courts. Random assignment was made to either a standard condition or to 2 enhanced conditions. The standard condition handled Drug Court cases routinely with court and urine supervision. The first enhanced condition, the treatment docket, enrolled drug-involved offenders into a comprehensive treatment program, and the second enhanced condition, the sanctions docket, used a systematic system of graduated sanctions and encouraged clients to enter treatment. Findings showed that drug use was reduced during the treatment program in both enhanced conditions. The sanctions docket conditions also realized lower 1-year post-treatment recidivism rates, and the treatment docket realized improved social functioning 1 year later.

Researchers as the University of South Florida evaluated 2 Drug Court programs established in Florida in 1993 (in Escambia and Okaloosa counties; Peters & Murrin,

2000). Drug Court graduates were compared to individuals assigned to the Drug Court clients who did not graduate from the program (Drug Court Non-Completers) and a comparison group of offenders who were matched on sociodemographic characteristics to the Drug Court clients, but who did not receive Drug Court treatment (No-Treatment Group) on recidivism and drug use during a 30-month follow-up interval. Findings showed that Drug Court graduates from both programs were significantly less likely to be rearrested and had fewer arrests than Drug Court non-completers and the no-treatment comparison group. Drug Court graduates also had lower rates of substance use.

An evaluation of 3 Kentucky Drug Court Programs (located in Fayette, Warren, and Jefferson counties) was recently conducted by researchers at the University of Kentucky (Logan, Leukefeld, & Minton, 2001). This evaluation combined a variety of data sources including official records and face-to-face interviews. A total of 745 individuals in 3 groups were examined, including a Drug Court Graduate group, Drug Court Non-Completers, and a Comparison group of individuals who had been assessed for Drug Court but who did not enter it. Findings from a 12-month follow-up showed that involvement in Drug Court was associated with reduced imprisonment, use of mental health services, and legal cost associated with criminal charges and convictions. Data also suggested that those who got Drug Court treatment had improved indicators for social adjustment, including increased earnings through employment and better child support payment records. Collectively, these strong findings for the effectiveness of Drug Courts in Kentucky suggest that they may be an important and underused avenue for providing needed transitional services upon offender reentry (especially following in-prison treatment episodes).

DEMOGRAPHIC PROFILE AND TREATMENT OUTCOMES FOR KENTUCKY REENTRY COURTS PILOT PROGRAM CLIENTS

Sample

A total of 7 clients were assigned to Reentry Court Pilot Programs by Judges in Fayette and Campbell Counties. Three Reentry Court candidates were identified by Judges in Warren County, but were never assigned to it because the Reentry Court team decided to suspend additional entries into the Reentry Court Pilot Programs. All 7 clients successfully completed the In-Prison Residential Phase of the Reentry Court Program. Of these, only 6 had entered the Drug Court phase of the Reentry Court Program (as of November 21, 2001). One client was finishing a residential half-way house, and was expected to begin the Drug Court phase in the near future. Therefore, demographic profile data described below will focus on all 7 clients, but outcome data will be reported only for the 6 clients who had actually entered the Drug Court Phase and thus had had some "at-risk" time in the community.

Method

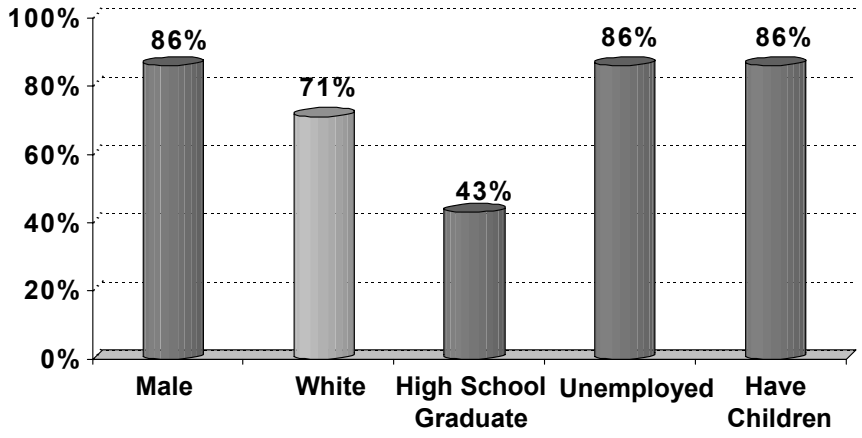
Demographic data. The Kentucky Drug Court Addiction Severity Index (KDCASI, Logan & Messer, 2000), a modified version of the Addiction Severity Index (McLellan, Kushner, Metzger, Peters, Smith, Grissom, Pettinati, & Argeriou, 1992) was used to collect information for developing a demographic profile of clients admitted to the Reentry Court Pilot Program. This included examinations of several major domains of client characteristics, including sociodemographic background, drug use history, criminal justice history, psychological problems, and treatment history. The original charge prompting entry into the Reentry Drug Court was coded from the Client's file.

Outcome data. Client files also were examined for indicators of during treatment performance. This included coding whether or not the client was employed during the Drug Court phase, results from urine tests for drug use, time in program, treatment status, sanctions, phase promotions, and whether or not a new charge was incurred during the Drug Court phase of the Reentry Court.

Demographic Profile Results

In terms of sociodemographic background (see Figure 2), the majority (86%) of the 7 Reentry Court Clients was male, white (71%), and not married (86%). The median age was 30 years old (range 20 - 37). Forty-three percent had graduated high school, and 71% had some vocational or technical training. Most (86%) were unemployed prior to entering the Reentry Court pilot program. Eighty-six percent had children (median = 1).

Figure 2. Sociodemographic Characteristics of Reentry Court Clients (N = 7)



Examination of drug use history information (See Table 1) showed that most had used a variety of drugs during their lifetime. All had used cocaine, and the median age at first use of cocaine was 19.5 (range 15-32). Most (86%) also had used alcohol, and the median number of years of regular use (i.e., on a weekly of more frequent basis) was 13 (range 0-22). Marijuana use also was common, and the median age of first marijuana use was 14 (range 10-17). Finally, multiple drug use was reported by 86% of the clients with a median of 4 years of regular use (range 0-22).

Table 1

Drug Use History for Reentry Court Clients (N = 7)

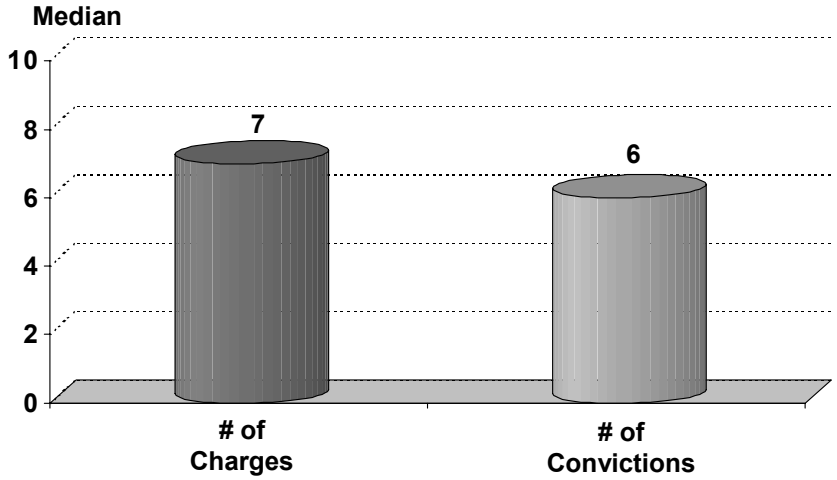
Drug	% Ever Used	Median Age of First Use	Median Years of Regular Use
Alcohol	86	15.0 (14-20)	13.0 (0-22)
Marijuana	86	14.0 (10-17)	8.0 (0-24)
Cocaine	100	19.5 (15-32)	4.0 (1-16)
Amphetamines	43	24.0 (13-36)	0.0 (0-1)
Barbiturates	50	20.0 (17-24)	0.5 (0-17)
Hallucinogens	57	16.0 (14-32)	1.0 (0-17)
Multiple Substances	86	15.0 (14-24)	4.0 (0-22)

Note. Regular use refers to use of a specific drug on a weekly of more frequent basis. Ranges appear in parentheses.

Most of the Reentry Court clients had a fairly serious criminal history (see Figure 3). All had histories of drug offense charges. Trafficking in a controlled substance (43%) was the most commonly cited admitting offense to Reentry Court (other charges included possession of a controlled substance, persistent felony offender, receiving stolen property, burglary, stalking, and probation violation). As shown in Figure 3, the median

number of prior charges was 7 (range 3-11), and the Reentry Court clients had a median of 6 convictions (range 2-9).

Figure 3. Criminal History Indicators for Reentry Court Clients (N = 7)



When lifetime rates of psychological problems (experienced independent of drug use) were examined, it was found that serious anxiety (57%) was the most frequently reported problem (See Figure 4). Forty-three percent reported they had been seriously depressed, 29% indicated they had had problems understanding, concentrating, or remembering (i.e., cognitive problems), and 29% indicated they had had trouble controlling violent behavior.

Figure 5 summarizes the treatment history of the Reentry Court Clients. Seventy-one percent had been in substance abuse treatment at least one time before (range 0-19 times). Fifty-seven had received outpatient-based substance abuse treatment services (range 0-7 times, including one individual who had been in Drug Court once before), and

57% had received residential treatment (range 0-12 times). Finally 43% had received treatment for psychological problems (range 0-12 times).

Figure 4. Lifetime Psychological Problems of Reentry Court Clients (N = 7)

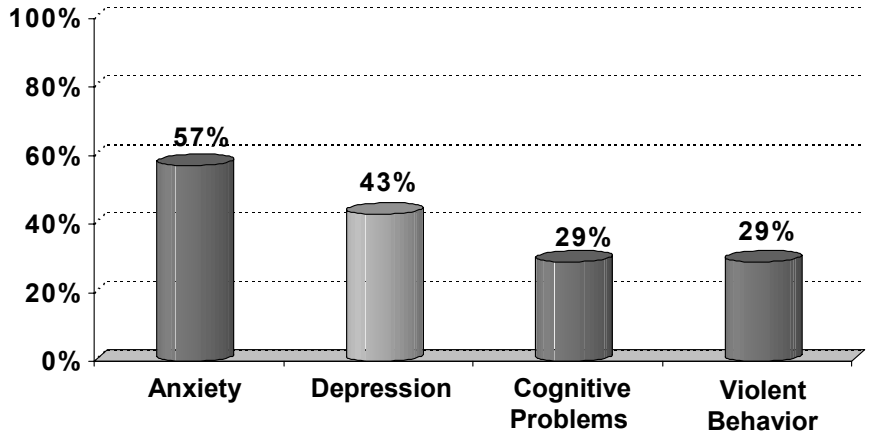
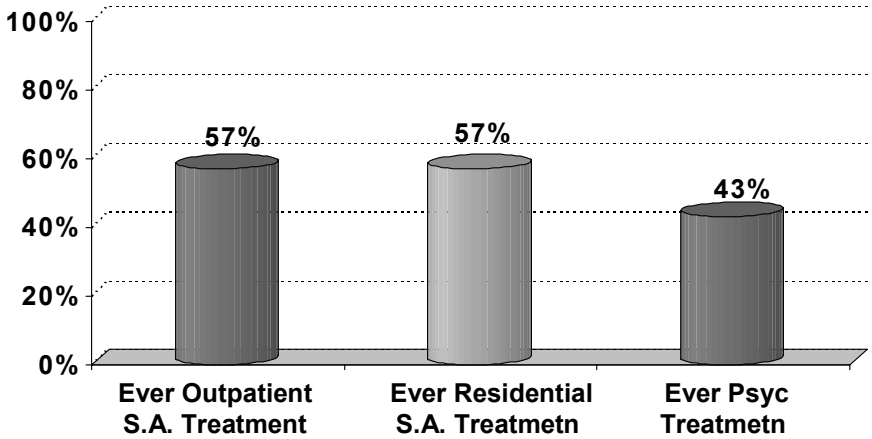


Figure 5. Treatment History of Reentry Court Clients (N = 7)



During Treatment Outcomes

Analysis of during treatment outcomes focused on the Drug Court phase of the Reentry Court pilot program, and included measures for time-in-program, status in program (i.e., active, discharged), phase promotions, urinalysis results, new criminal charges, employment, and education. During program data were available on 6 clients, but they were not available for 1 client who was finishing treatment in a residential halfway house prior to entering the Drug Court phase of the Reentry Court Pilot Program.

Initial findings were positive. Analysis of the during program performance data showed that almost all of the clients were doing well in the program (as of November 21, 2001). Five of the six clients (83%) in the Drug Court phase were still actively in treatment; 1 client had absconded. The median time-in-program was 77 days (range 34-373 days), and 4 clients had been received a phase promotion in Drug Court (1 had been promoted twice); thus, 1 client was in phase 1, 3 clients were in phase 2, and 1 client was in phase 3 of Drug Court. In terms of urinalysis data, none of the Reentry Court pilot clients had submitted a drug-positive urine screen, 3 clients had missed 1 urine drop, and 1 client had submitted two "abnormally diluted" urine tests. This indicates that the Reentry Court clients likely were not using illicit drugs during Drug Court. No Reentry Court clients were charged with a new offense. Only 4 clients had received a sanction, including 4 who had been given community service hours to complete, 2 who were given a brief incarceration episode, and 1 who was given day reporting. Finally, although most Reentry Court clients (86%) were unemployed prior to entering the Drug Court phase, 67% gained employment during Drug Court.

DEVELOPMENT AND INITIAL VALIDATION OF A TREATMENT SCREENING QUESTIONNAIRE

Although it was hoped initially that the Kentucky Reentry Court Pilot Program would be able to combine the treatment effectiveness of both in-prison treatment and Drug Court treatment, it was apparent that a screening questionnaire was needed to help inform the treatment referral process for the 6-month in-prison substance abuse treatment phase of the Reentry Court program. The following is a description of the pilot work completed on the development of a Treatment Screening Questionnaire that might be useful for other jurisdictions in their decision making processes as they are planning specialized Reentry Courts. The entire Treatment Screening Questionnaire may be found in the Appendix.

Need for a Screening Tool

As described by Peters and Peyton (1998), screening and assessment often are treated as discrete but continuous events in the context of Drug Courts, and that all Drug Courts need to conduct each on their clients. Treatment screening instruments are typically brief, and act as a means for triaging possible treatment candidates into a much more in-depth assessment process designed to provide a more comprehensive psychosocial picture of the individual, leading to the development of an individualized treatment plan (Peters, 1992). Assessing each treatment candidate in a structured manner is integral to helping the treatment programs like Drug Courts and in-prison therapeutic communities to determine if the individual is abusing alcohol and/or illicit drugs and to understand which pathway (i.e., biological, psychological, social and environmental, or spiritual) is the strongest determinant of this behavior (Leukefeld, Hiller, Walker, Logan, & Staton, in press). As previously mentioned, this assessment process generally is

conducted in a hierarchical manner, beginning first with a brief screen to determine the level of substance abuse problems, followed by an in-depth assessment (frequently conducted as a face-to-face interview) when problems are evident. The primary goal of both screening and assessment, therefore, is to provide information essential to making appropriate referrals as well as accurate and reasonable treatment plans (Leukefeld, Hiller, Walker, Logan, & Staton, in press).

More specifically, screening refers to the initial process for determining the appropriateness of an individual for entry into Drug Court, both legally and clinically. Legal screening usually is done by criminal justice representatives and attempts to determine legal eligibility and examine possible public safety risk (Peter & Peyton, 1998, Cooper, 1997). Clinical screening examines drug use severity and the individual's willingness to participate in the program. Peters and Peyton (1998: pp. 11-12) in their monograph on screening and assessment for Drug Courts recommend that a treatment screen should include these core elements (a) background and demographic information, (b) substance use, (c) mental health, (d) criminal history, and (e) other focus areas, including treatment motivation.

For the current study, both Reentry Courts pilot sites assessed potential clients with the Kentucky Drug Court Addiction Severity Index (Logan & Messer, 2000). However, correctional managers indicated that they wished to change the treatment eligibility screen that they had been using for determining whether an individual was appropriate for admittance into the 6-month in-prison substance abuse treatment programs. Therefore, a treatment screen was developed (see Appendix) using the

recommendations provide by Peters and Peyton (1998) to help provide information necessary for determining if an offender is appropriate for in-prison treatment placement.

Treatment Screening Questionnaire

With input from the Kentucky Department of Corrections, Division on Substance Abuse and Mental Health, it was decided that a treatment screen should focus on the offenders' demographic background, substance use, mental health and treatment history, treatment motivation, and criminal history. A variety of short standardized clinical instruments were selected for inclusion in the screen based on their prior use in prison populations and because all were in the public domain; and therefore, free-of-charge to make it as economical as possible for use on a larger-scale. The following is a description of the specific components of the Treatment Screening Questionnaire.

Demographic background. A brief description of the offenders' background was included in the first 2 pages of the treatment screening questionnaire. The offender was asked to write his/her name, prison identification number, and then to record his/her age, date of birth, ethnic background, legal marital status, and educational background on the questionnaire.

Substance use and dependence. Two standardized instruments were included in the treatment questionnaire to assess drug use severity (i.e., the Simple Screening Instrument and the TCU Drug Screen). The Simple Screening Instrument (Center for Substance Abuse Treatment, 1994) was developed as a brief 16-item questionnaire for identifying individuals who might need substance abuse treatment. [It may be found on the third and fourth pages of the Treatment Screening Questionnaire (Part B: Simple Screening Instrument)]. The prisoners were asked to indicate "yes" or "no" to a series of

questions about their substance abuse in the 6 months preceding the charge that resulted in their incarceration. Sample items include "Did you use alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin or other opiates, uppers, downers, hallucinogens, or inhalants)" and "Did drinking or other drug use cause problems between you and your family or friends?" It has been tested and recommended for use with correctional populations like prison inmates (Peters, Greenbaum, Steinberg, Carter, Ortiz, Fry, & Valle, 2000). Only items 2 through 14, and item 16 are used when scoring the Simple Screening Instrument. For each "yes" answer on these 14 questions, 1 point is given. By summing the "yes" answers one gets a final score (range 0-14 points total). Scores from 0-1 indicate no risk for drug abuse, 2-3 indicates minimal risk for drug abuse, and 4 and above indicates that it is likely that drugs are being abused and further assessment is needed (Center for Substance Abuse Treatment, 1994).

The Texas Christian University Drug Screen II (TCUDS II, Simpson & Knight, 1998) was the second instrument used for determining the prisoners' drug use severity. [It can be found on the sixth and seventh pages of the Treatment Screening Questionnaire (Part F: TCU DDS II)]. Like the Simple Screening Inventory, the TCUDS II is a brief tool for quickly identifying individuals who report heavy drug use or dependency (and it is based on the Diagnostic Statistical Manual and the NIMH Diagnostic Interview Schedule). It asked a series of 9 "no-yes" questions about the offenders drug use in the 12 months preceding the charge that resulted in their incarceration. Sample questions included "Did you use larger amounts of drugs or use them for a longer time than you had planned or intended?" and "Did you spend a lot of time getting drugs, using them, or recovering from their use?" It is widely used in state correctional systems, including

Texas and California (Knight, Simpson, & Hiller, in press). The TCUDS II is easy to score. For questions 1-9, the individual gets 1 point for each "yes" they answer (range 0-9 points). One can score only 1 point for questions 4 and 6, even if multiple subparts are answered "yes". A score of 3 or above indicates serious drug problems (Simpson & Knight, 1998).

Mental health and treatment history. Mental health was assessed in the Treatment Screening Questionnaire with the psychological status section of the Addiction Severity Index, an instrument normed for use with correctional inmates (McLellan, Kushner, Metzger, Peters, Smith, Grissom, Pettinati, & Argeriou, 1992). Prisoners were asked to respond either "yes" or "no" on a series of questions that included "Have you ever experienced serious depression?" "Have you ever experienced hallucinations?" and "Have you ever attempted suicide?" [This can be found on the fourth and fifth pages of the Treatment Screening Questionnaire (Part C: Psychological Information)]. Questions concerning the mental health and substance abuse treatment experiences followed this section included "Have you taken any prescribed medications for psychological or emotional problems in the last 6 months?" and "How many times before now have you ever been in a drug abuse treatment program?

Treatment motivation. Cognitive readiness for treatment was measured through the Desire for Help scale from the TCU Motivation Assessment (Simpson & Joe, 1993). It was comprised of items like "You need help in dealing with your drug use" and "It is urgent that you find help immediately for your drug use." A Likert scale was used so that those who completed the screen could mark responses ranging from "strongly disagree" to "strongly agree." [This can be found on the fifth page of the Treatment Screening

Questionnaire (Part D: Treatment Scale)]. Scores for desire for help are computed by averaging the responses to the 7 items. Scores on this scale have been shown to be predictive of engagement in corrections-based substance abuse treatment (Hiller, Knight, Leukefeld, & Simpson, in press).

Criminal history. Risk to public safety was measured through the Salient Factor Score (SFS; Hoffman & Adelberg, 1980). [The SFS can be found on the fifth and sixth pages of the Treatment Screening Questionnaire (Part E: Criminal History)]. This is an actuarial inventory used for determining the relative probability of one committing a crime and being reincarcerated after release from prison. The predictive validity of this risk classification system, originally developed by the U.S. Parole Commission, is well established (see Hoffman & Beck, 1976; Hoffman & Beck, 1980; Hoffman, 1983, and Hoffman & Beck, 1985). It is a nine-item instrument that focuses on criminal and drug use history, education level, previous employment, and the offender's release plan. Scores range from 0 to 11, with higher values representing better risks for positive parole outcomes. Traditionally, parolees who scored between 9 and 11 were classified as having a "very good parole prognosis," those with 6-8 points were labeled "good risks," cases with 4-5 were considered "fair prospects," and those scoring between 0 and 3 were regarded as parolees who presented "poor parole risks." (Hoffman, 1994).

Validation of the Treatment Screening Questionnaire

The Treatment Screening Questionnaire was pilot tested in a corrections-based therapeutic community for men, the Luther Luckett Correctional Complex Substance Abuse Program (LLCC-SAP). This program was a primary placement for Reentry Court clients; 3 of the 7 Reentry Court clients were assigned to residential treatment here.

Initial finding on the reliability and validity of this screen are favorable, suggesting that additional testing is needed in other programs (including other Reentry Court sites).

Validation sample. Thirty-nine residents completed the Treatment Screening Questionnaire. All were male, 67% were white, 28% were African American, and 5% were American Indian. The average age of the resident was 33, and 39% had never been married, 28% were married or living as married, 33% were divorced or separated. The average number of year of education completed was 11.5, and 81% had graduated high school or received a graduate equivalency diploma (GED, see Table 2).

Validation procedure. Residents at the LLCC-SAP were asked by CDAR researchers to volunteer for a treatment study during which they would be asked to complete a brief questionnaire. Those who volunteered were organized into small testing groups, and after informed consent was given, a researcher read the Treatment Screening Questionnaire to each group. The residents read along with the researcher and marked their responses on their copy of the questionnaire (see Appendix for a copy of the treatment screener). Each testing session took approximately 15 minutes after informed consent was given.

Official records also were examined for comparison to the self-report. Peters and Peyton (1998) note that offender self-report may be suspect and recommend cross-validation of information elicited via self-report questionnaires with information contained in official or collected through biological assays (e.g., urinalysis). Two CDAR researchers audited the criminal records for the individuals who completed the screen, coding information from institutional records and the post-sentencing investigation report (PSI). However, only limited amounts of information in the PSI and information

collected with the Treatment Screening Questionnaire were directly comparable. Only demographic and criminal history information was available for comparison.

Analyses. Descriptive statistics were first calculated for each Treatment Screening Questionnaire item, including percentages, means, ranges, and standard deviations. Next internal consistency reliability coefficients (Cronbach's Alpha) were calculated for the standardized measures sections of the Treatment Screening Questionnaire (i.e., the Simple Screening Instrument, Desire for Help Scale, Salient Factor Score, and TCU Drug Screen II). This provided a measure for how well the individual items in the scale correlated with each other (indicating they are measuring a related construct). Scaled scores were then computed for these sections, and a series of bivariate correlations were calculated between these scaled scores.

The final analytic step involved the comparison of the self-reported information with the information abstracted from official records. The analytic strategy used for this follows that discussed in other studies that have sought to validate self-reported information with official records (c.f., Broome, Knight, & Simpson, 1996; Knight, Hiller, Simpson, & Broome, 1998). This analytic strategy included the calculation of the percentage agreement between the self-report and the official records on individual items. For example, if 79% of the answers on a particular item were found to agree, then this would indicate that 79% of the residents that had indicated "yes" on the Treatment Screening Questionnaire and the official record also had indicated "yes" or that the residents who had answered "no" and the official record also indicated "no" in their self-report information. In addition to this, reliability coefficients were calculated to indicate the relative magnitude of agreement between the self-reported and official record

information. For items that were dichotomously-scaled (e.g., no or yes), the Kappa coefficient was calculated. Kappa (κ) is a statistic that approximates the proportion of agreement while correcting for chance agreement (Cohen, 1960). When agreement between two measures is perfect, κ equals 1, and the values of the row and column marginals are equivalent (Fleiss, 1981). A Pearson's r correlation coefficient was calculated for items that were continuously-scaled (e.g., # of times incarcerated). A r of 1 would indicate perfect agreement between the self-report and official record data, so larger positive coefficients represent more agreement between items than positive smaller coefficients.

Results. Responses to individual items on the Treatment Screening Questionnaire are presented in Table 2. Overall, findings showed that residents were willing to self-disclose information concerning their drug use, treatment motivation, psychological status, and criminal history. Missing data were uncommon. Responses on the Simple Screening instrument ranged from 100% of the residents indicating they had used alcohol or other drugs (Question 1) to 5% indicating they had experienced convulsions or delirium tremens (Question 5c) (See Table 2). More than 80% indicated that drinking or other drug use had caused problems with family or friends (92%), caused problems as school or work (85%), that they had lost their temper or gotten into fights or arguments while drinking or using drugs (87%), that they had to drink or use drugs more and more to get the same effect (85%), that they were more likely to do things they wouldn't normally do when they were drinking or using drugs (92%), and that other family members had had a drinking or drug abuse problem (82%).

The residents also reported a fairly large number of psychological problems. Forty-nine percent indicated that they had experienced serious depression in their lifetime, 59% indicated severe anxiety, 21% hallucinations, 56% trouble understanding, concentrating or remembering, and 44% trouble controlling violent behavior. In regards to Desire for Help, most indicated either "agreement" or "strong agreement" to each item. For example, the average response to "You want to get you life straightened out" was 4.9 (SD = 0.3), indicating strong endorsement of this item by all residents. The smallest value (mean =3.6, SD = 1.4) was found for the statement "It is urgent that you find help immediately for your drug use."

For criminal history, the residents reported an average of 11.9 convictions in their lifetime, and an average of 10.5 incarceration episodes. The average age at first incarceration was 16.3 years old (SD = 6.4). Seventy-seven percent indicated that they had had either their probation or parole revoked before, and 90% indicated someone else had told them that they had either a drug or alcohol problem. Fifty-nine percent had been incarcerated for a violent crime like assault or robbery.

Finally, response patterns on the TCU Drug Screen II were similar to those for the Simple Screening Instrument. Most responded "yes" to several indicators for having a clinically-significant drug or alcohol problem. For example, 82% indicated they spent a great deal of time getting drugs, using them, or recovering from their effects (Item 3). Ninety percent indicated that drug or alcohol use had caused problems with friends, family, work or police, 50% indicated it had caused emotional or psychological problems, and 42% reported drug-related physical health or medical problems (Items 6a, 6b, and 6c, respectively).

Table 2

Frequencies and Averages for Responses on the Treatment Screener Questionnaire (N=39)

Questionnaire Section	Percent or Average
A. Background Information	
1. How old are you?	32.8 (6.59)
3. What is your race or ethnic background?	
1. African American/Black	28
2. American Indian	5
3. Asian/Pacific Islander	0
4. Mexican American (Hispanic origin)	0
6. White (not of Hispanic origin)	67
4. What is your legal marital status?	
1. Never married	39
2. Legally married	23
3. Living as married (including common law marriage)	5
4. Separated	8
5. Divorced	25
6. Widowed	0
5. How many years of school have you finished -- that is, what is the highest grade you completed?	11.5 (1.6)
6. Have you --	
a. graduated from high school?	19
b. completed a vocational or technical training program?	46
c. Have you completed your GED?	62
d. Are you currently working on your GED or any type of vocational/technical training certificate?	16
Part B: Simple Screening Instrument[1]	
1. Did you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin or other opiates, uppers, downers, hallucinogens, or inhalants)	100
2. Did you feel that you used too much alcohol or other drugs?	74

Table 2

(Continued)

Questionnaire Section	Percent or Average
Part B: Simple Screening Instrument (Continued)	
3. Did you try to cut down or quit drinking or using alcohol or other drugs?	41
4. Did you go to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program)	33
5. Did you have any health problems? For example, did you:	
5a. Have blackouts or other periods of memory loss?	46
5b. Injure your head after drinking or using drugs?	14
5c. Have convulsions, delirium tremens ("the DTs")?	5
5d. Have hepatitis or other liver problems?	13
5e. Feel sick, shaky, or depressed when you stopped?	55
5f. Feel "coke bugs" or a crawling feeling under your skin after you stopped using drugs?	30
5g. Get injured after drinking or using?	47
5h. Use needles to shoot drugs?	29
6. Did drinking or other drug use cause problems between you and your family or friends?	92
7. Did drinking or other drug use cause problems at school or at work?	85
8. Were you arrested or had other legal problems because of your drug use? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession)	92
9. Did you lose your temper or get into arguments or fights while drinking or using drugs?	87
10. Did you need to drink or use drugs more and more to get the effect that you wanted?	85

Table 2
(Continued)

Questionnaire Section	Percent or Average
Part B: Simple Screening Instrument (Continued)	
11. Did you spend a lot of time thinking about drinking or trying to get alcohol or other drugs?	74
12. When you drank or used drugs were you more likely to do something you wouldn't normally do, such as break the law, sell things that were important to you, or have unprotected sex with someone?	92
13. Did you feel bad or guilty about you drinking or drug use?	64
14. Have you ever had a drinking or other drug problem?	79
15. Have any of your family members ever had a drinking or a drug problem?	82
16. Do you feel that you have a drinking or a drug problem now?	50
Part C: Psychological Information	
1. Not counting the effects from alcohol or other drug use, have you ever experienced [1] --	
a. serious depression?	49
b. serious anxiety or tension?	59
c. hallucinations (hearing or seeing things that others thought were imaginary)?	21
d. trouble understanding, concentrating, or remembering?	56
e. trouble controlling violent behavior?	44
f. serious thoughts of suicide?	n/a[2]
g. attempts at suicide?	n/a[2]
2. Have you taken any prescribed medications for psychological or emotional problems in the last 6 months?	16
3. How many times before now have you ever been treated for psychological or emotional problems?	.6 (1.1)
4. How many times before now have you ever been in a drug abuse treatment program?	.8 (1.3)

Table 2
(Continued)

Questionnaire Section	Percent or Average
Part C: Psychological Information (Continued)	
5. How many times have you ever been in any kind of treatment program for drinking or alcohol problems?	1.0 (1.9)
Part D: Treatment Scale[3]	
1. You need help in dealing with your drug use.	4.1 (1.1)
2. It is urgent that you find help immediately for your drug use.	3.6 (1.4)
3. You are tired of the problems caused by drugs.	4.6 (0.7)
4. You will give up your friends and hangouts to solve your drug problems.	4.5 (0.9)
5. You can quit using drugs without any help (R).	3.8 (1.4)
6. Your life has gone out of control.	3.7 (1.4)
7. You want to get your life straightened out.	4.9 (0.3)
Part E: Criminal History	
1. Altogether, how many times have you been convicted of a crime in your life?	11.9 (19.2)
2. How many times during your whole life have been in Jail, Prison, or Juvenile Lock-up?	10.5 (10.3)
3. How old were you the first time you were put in jail, prison, or juvenile lock-up?	16.3 (6.4)
4. Are you currently in jail/prison for theft, auto theft, or forgery?[1]	69
5. Have you ever had your probation/parole revoked?[1]	77
5a. Have you ever been put in jail/prison while you were on probation/parole because you had committed a new crime? [1]	54
6. Have you ever been told that you had drug or alcohol problem? [1]	90

Table 2
(Continued)

Questionnaire Section	Percent or Average
Part E: Criminal History (Continued)	
7. Have you ever been employed full-time (at least 35 hours per week) for at least 6 months out of the last 2 years?[1]	49
8. Have you ever been a gang member?[1]	5
9. Have you ever been in jail/prison for a violent crime like assault, robbery, manslaughter, murder, rape, or for violent threats?[1]	59
Part F: TCU DDS II[1]	
1. Did you use larger amounts of drugs or use them for a longer time than you had planned or intended?	74
2. Did you try to cut down on your drug use but were unable to do it?	56
3. Did you spend a lot of time getting drugs, using them, or recovering from their use?	82
4. Did you get so high or sick from drugs that it--	
a. kept you from doing work, going to school, or caring for children?	62
b. caused and accident or put others in danger?	56
5. Did you spend a less time at work, school, or with friends so that you could use drugs?	66
6. Did your drug use cause--	
a. emotional or psychological problems?	50
b. problems with friends, family, work, or police?	90
c. physical health or medical problems?	42
7. Did you increase the amount of a drug you were taking so that you could get the same effects as before?	82
8. Did you ever keep taking a drug to avoid withdrawal or keep for getting sick?	33

Table 2
(Continued)

Questionnaire Section	Percent or Average
Part F: TCU DDS II[1] (Continued)	
9. Did you get sick or have withdrawal when you quit or missed taking a drug?	39

Note: Standard deviations appear in parentheses. An (R) indicates the item should be reverse coded before calculation of scaled score.

[1] Response scale was 0 = 'no' and 1 = 'yes.' The percentage reflects the 'yes' responses to the specific item.

[2] This question was not asked.

[3] Response scale ranged from 1 = 'strongly disagree' to 5 = 'strongly agree.'

Analyses next focused on the internal consistency reliability of the standardized instruments contained in the Treatment Screener Questionnaire; that is, the Simple Screening Instrument, Desire for Help Scale, Salient Factor Score, and the TCU Drug Screen II). Findings described in Table 3 showed that the Simple Screening Instrument was internally consistent (Cronbach Alpha = .70), and the average score on the scale was 9.74 (SD = 2.49, range 5-13) out of a total of 14 points possible. 100% of the sample scored 5 or above on the SSI, indicating they were all showing a "moderate-to-high" probability of having an alcohol or drug abuse problem. Estimates of internal consistency reliability also were good for the Desire for Help Scale (Cronbach Alpha = .75), most indicated a fairly high degree of treatment motivation (Mean = 4.15, SD = .69, Range 2.57- 5.00). This is higher than scores reported by inmates in a psychoeducational substance abuse treatment program, and inmates sampled from the general prison

population (see Hiller, Leukefeld, Staton-Tindall, & Kayo, 2001). Examination of the Salient Factor Score (Cronbach Alpha = .56) showed that most residents had serious criminal histories (Mean = 2, SD=1.57, Range 0-7). Thirty-three (84%) of the residents scored between '0' and '3' indicating they had very serious criminal histories. Although this finding might seem contraindicative for outcomes from residential prison-based treatment or Reentry Court, a growing body of literature indicates that the intensive treatment services represented by these types of programs should be reserved for this particular type of offender because it represents their best chance for changing their addictive and criminal lifestyle (Gendreau, Cullen, & Bonta, 1994; Knight, Simpson, & Hiller, 1999). Finally, analysis of the TCU Drug Screen II showed a high degree of internal consistency reliability for this scale (Cronbach Alpha = .82). The average score on the TCUDS II was almost 6 (SD = 2.5, Range 0-9), and 79% scored 3 or above suggesting clinically significant alcohol or drug problems.

Table 3

Coefficient Alphas, Means, and Possible Ranges for Standardized Scales in the Treatment Screener Questionnaire (N=39)

Standardized Scale	Alpha	Mean	Possible Range
Simple Screening Instrument (Section B, Items 2-15)	.70	9.74 (2.49)	0-14
Desire for Help Scale (Section D, Items 1-7)	.75	4.15 (0.69)	1-5
Salient Factor Score (Section E, Items 1-7)	.56	2.00 (1.67)	0-11
TCU Drug Screen II (Section F, Items 1-9)	.82	5.95 (2.50)	0-9

Note: Standard deviations appear in parentheses.

The final set of analyses for examining the initial validity of the Treatment Screening Questionnaire focused on comparing the agreement between the self-reported information provided by the residents, and the information abstracted from official records. As previously noted, only 2 areas were focused on in these analyses (i.e., demographics and criminal history) because theses were the only 2 areas that information comparable to that elicited by the treatment screener could be found in the residents' official files. Overall, findings showed a high level of agreement between self-report and the official record, and when disagreements were noted, they generally were due to the resident reporting more information than was found in the official record.

Findings showed perfect agreement ($\kappa = 1.0$) between the resident's self-reported race/ethnicity and that coded from their official records (see Table 4). In terms of marital status, overall, agreement between the self-report and the official record was good (κ's ranged from .45 to .65). Analysis of disagreements showed that 5 individuals reported on the Treatment Screening Questionnaire that they were married (or living as married), a status not reflected for them in the official file. Similarly, 4 indicated they were divorced or separated (also not reflected in the official record). Agreement on the educational background items was strong. Agreement for total years of education was good ($\underline{r} = .61$) and kappa coefficients for high school graduation, and GED (κ = .80 and .58, respectively) showed high levels of agreement between self-report and official records. Analysis of disagreements between self-report and official records showed that 2 individuals indicated on self-report that they were high school graduates, and 7 reported having a GED that was not reflected in the official record.

Analysis of the agreement between self-reported criminal history and data from the post-sentencing investigation report for each resident generally showed modest levels of agreement, and frequently residents reported more extensive criminal histories than what was reflected in the official record. Pearson correlation coefficients showed moderate agreement for the number of times residents had been convicted for a crime and the number of times residents had be incarcerated ($\underline{r}$ = .31 and .47, respectively). Sixty-five percent of the cases examined were in agreement on whether the resident had ever had their probation or parole revoked (κ = .27). It is interesting to note that 10 residents reported a probation or parole revocation that was not evident in their official file. Finally, moderate agreement (κ = .41) was found between the resident's self-report of ever having been incarcerated for a violent crime and the official record. Six clients reported an incarceration for a violent offense that was not recorded in the post-sentencing investigation.

In summary, initial application of the Treatment Screening Questionnaire was encouraging. The questionnaire took only 15 minutes to complete, and could be completed effectively in a small group setting with a single tester, thus limiting costs for this type of assessment. The standardized scales (SSI, Desire for Help, SFS, and TCUDS) were internally consistent, suggesting good measurement properties for the entire screener. The residents answered most of the questions asked, and data showed that they generally reported more information than was contained in their official file. Together, these finding suggest that the residents were willing to report on their drug use, motivation, psychological status, and criminal history. Additional study appears to be needed to provide additional normative and validation data for this screener.

Table 4

Comparison of Self-Reported Data with Data from Official Records (N=39)

Questionnaire Content	Self-Report	Official Record	Percent Agreement	(+) Self-report, (-) Official Record (n)	Kappa/ r
Demographics					
Race/Ethnicity					
% African American	30 (n=37)	30 (n=38)	100	n/a	1.0 (n=36)
% White/Caucasian	70 (n=37)	70 (n=38)			
Marital Status					
% Never married	39 (n=39)	55 (n=33)	82	0	.65 (n=33)
% Married	28 (n=39)	21 (n=33)	79	5	.45 (n=33)
% Divorced/separated/ widowed	33 (n=39)	24 (n=39)	85	4	.63 (n=33)

Table 4
(Continued)

Questionnaire Content	Self-Report	Official Record	Percent Agreement	(+) Self-report, (-) Official Record (n)	Kappa/ r
Education					
Highest grade completed (average)	11.5 (n=39)	11.27 (n=34)	n/a	n/a	.61 (n=34)
% High school graduate	19 (n=37)	15 (n=34)	94	2	.80 (n=32)
% GED	62 (n=37)	41 (n=33)	78	7	.58 (n=32)
% Vocational/Technical	45 (n=33)	18 (n=24)	77	5	.49 (n=22)
Criminal History/Salient Factor Score					
# Times Convicted of a Crime (average)	11.9 (n=35)	12.2 (n=34)	n/a	n/a	.31 (n=31)
% 1 to 10 convictions	74 (n=35)	71 (n=34)	71	n/a	.27 (n=31)

Table 4
(Continued)

Questionnaire Content	Self-Report	Official Record	Percent Agreement	(+) Self-report, (-) Official Record (n)	Kappa/ r
# Times incarcerated (average)	10.5 (n=35)	5.8 (n=34)	n/a	n/a	.47 (n=31)
% 1 to 10 incarcerations	71 (n=35)	85 (n=34)	68	n/a	.12 (n=31)
% Currently in prison for theft, auto theft, or forgery	69 (n=39)	18 (n=34)	53	16	.21 (n=34)
% Ever had probation/parole revoked	77 (n=39)	53 (n=34)	65	10	.27 (n=34)
% Ever incarcerated for violent crime	59 (n=39)	53 (n=34)	71	6	.41 (n=34)

Note. Kappa coefficients were calculated for dichotomously-scaled variables, and Pearson's r was used for continuously-scaled variables. The number of participants providing data for each item is summarized in the parentheses below each number.

CONCLUSIONS AND RECOMMENDATIONS

As hundreds of thousands of offenders return to the community each year, the need for effective reentry programming will become paramount. Reentry Courts represents a national recognition of the offender reentry issue and are an important attempt at developing programming to help offenders to live productive, crime-free, drug free lives after they are released from prison and jail.

The Kentucky Reentry Court pilot program was firmly grounded in a body of literature that shows that treatment for drug-involved offenders can be effective for reducing recidivism to the criminal justice system and relapse to drug use among offenders with serious drug-related problems. It combined two approaches, residential prison-based treatment and community-based Drug Courts, repeatedly shown to help drug-involved offenders to begin their recovery and lead prosocial lives. In this model, Reentry Court clients received 6 months of prison-based treatment, and then were shock probated and entered into an established Drug Court. However, after admitting 7 clients to the pilot program, this model was discontinued because the availability of Federal funding for innovative reentry programming was severely limited.

Initial findings for the 6 clients who have progressed into the Drug Court phase of the Reentry Court pilot program suggests that combining prison-based treatment and Drug Court shows promise. As of November 21, 2001, 5 of the 6 clients were still active in treatment (1 had absconded). These individuals showed high levels of behavioral compliance with treatment expectations. Several have been promoted to either phase 2 or phase 3 of the Drug Court, none have tested positive for and illicit drug on urine tests,

none had received a new criminal charge, and most were employed; whereas, the majority were unemployed prior to entering Drug Court.

A Treatment Screening Questionnaire also was developed during the course of this evaluation project that shows promise for helping to identify individuals in need of rehabilitative programming like Reentry Courts. This screener combined several instruments to cover major content areas suggested by Peters and Peyton (1998), including sociodemographic background, drug use, treatment motivation, psychological status, treatment history, and criminal history. Initial findings for this screener showed that offenders were willing to provide self-reported information about their drug use, treatment history, and psychological status. These self-reports were internally consistent, and showed a high level of agreement with information contained in official records, suggesting good reliability and validity for this questionnaire.

Finding from the current evaluation suggest the following recommendations. First, combining Drug Court with in-prison treatment appears to have merit. This concept was based firmly on a growing body of literature that indicates these approaches are effective, and initial finding from the during program performance of the clients in the Kentucky's Reentry Court pilot program suggests that this combination will be effective for reducing relapse and recidivism. Second, the capacity of both corrections-based treatment and Drug Courts likely will need to be increased in the near future. Many drug-involved offenders are housed in prisons, and most of these will return to the community with little or no services for their drug problems. Hopefully, by increasing services for drug involved offenders, the revolving door on courts and corrections for these individuals may be slowed for some and stopped for others.

In conclusion, the Kentucky Reentry Court Pilot program was grounded in the literature that shows residential treatment and Drug Courts are effective for reducing recidivism and relapse among drug-involved offenders. Initial findings from analysis of program performance indicators showed that most of the clients admitted to the Reentry Court program were doing well in it; therefore, additional federal monies should be made available to more thoroughly test innovative programs for helping offenders reenter and reintegrate into the community.

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APPENDIX

TREATMENT SCREENING QUESTIONAIRRE